UNITED STATES OF AMERICA

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DEPARTMENT OF DEFENSE

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ARMED FORCES EPIDEMIOLOGICAL BOARD

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PUBLIC MEETING

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Wednesday,
September 15, 1999

The meeting continued in the Sanford Auditorium at the Uniformed Services University of Health Sciences, Bethesda, Maryland, at 7:30 a.m., Dr. Dennis Perrotta, AFEB President, presiding.

PRESENT:

DENNIS M. PERROTTA, Ph.D.	President
HENRY A. ANDERSON, M.D.	Member
DAVID ATKINS, M.D.	Member
SUSAN P. BAKER, M.P.H.	Member
L. JULIAN HAYWOOD, M.D.	Member
FRANCOIS M. LAFORCE, M.D.	Member
STANLEY I. MUSIC, M.D.	Member
GREGORY A. POLAND, M.D.	Member
ARTHUR L. REINGOLD, M.D.	Member
ROSEMARY K. SOKAS, M.D.	Member
COL. BENEDICT M. DINIEGA, USA	Executive Secretary

ALSO PRESENT:

MARGARET THOMPSON
CAPTAIN DAVID TRUMP, USN
COL. DANA BRADSHAW, USAF
LTC(P). DAN WITHERS, USA
CAPT(S). KEN SCHOR, USMC
LCDR. SHARON LUDWIG, USCG

I-N-D-E-X

P-R-O-C-E-E-D-I-N-G-S

(7:44 a.m.)

PRESIDENT PERROTTA: Under the heading of flexibility we have, we're waiting for a Consultant for the Health Promotion Maintenance Group, so here's what I'd like to do. He's supposed to show up around ten, and I hope he'll show up a little earlier. What we're going to do is we're going to have Lieutenant Colonel Fonseca give his Preventive Health Care Application presentation now. He's here.

We will immediately after that go into Executive Session. And as far as I'm concerned everybody can stay. I don't think we have anything that is, makes this a closed meeting. After Executive Session we will go to a 30 minute session for Subcommittees, max 45. Two out of three have said 30 is all that they need.

So that the Board can hear what has occurred in those Subcommittees, we will meet back here for a few minutes and then wrap things up at that point. I've estimated, I'm estimating we'll get out by 11:00. That is my goal.

AUDIENCE MEMBER: Is it a hurricane?

PRESIDENT PERROTTA: That's what

everybody is asking me. I, you know, they say good morning, Dennis. And the next words out, is there anyway that we can finish up a little early so we can make a plane to get home before the storm hits. Even when they live in California, they were asking me to do that. So I don't understand that.

(Laughter.)

PRESIDENT PERROTTA: Is that, does that cause hardship in anybody, both Participants or -- so we're going to do our talk this morning, first, Executive Committee, Subcommittees and then come back again very quickly and hear the reports for the Subcommittees, hit the gavel and we'll go home.

AUDIENCE MEMBER: You've got a gavel today?

PRESIDENT PERROTTA: Yes, somebody, the gavel showed up this morning. The last time I saw Lieutenant Colonel Fonseca he had a green uniform on, so I don't know where he's from anymore. So if you would let us know that once you get going. And I guess I'll call the meeting to order. I didn't get to do that yesterday.

LTC. FONSECA: Okay, my name is Fonseca and here's our web site at the bottom where you can

find out pretty much everything you want to know, at least from the Air Force's perspective, what's going on with prevention in the military. I'm in OPHSA, which is the Air Force's Office for Prevention Health Services Assessment at Brooks Air Force Base. So that's where I am.

What I'm going to talk about very quickly is why did we start this to begin with, mainly around some optimal outcomes that we had in a variety of areas related to our suboptimal processes, and then review what PHCA really does. Obviously our job one is to deliver a healthy, fit and ready force. And we couldn't do that because we couldn't track what was going on for a variety of individual medical readiness items.

The most obvious one is shots. We didn't have shot software, shot tracking system and other things weren't easy to review either. As many of you know, our Desert Storm efforts led to a variety of force health protection and we needed to track better what was going on with people day in and day out or year in and year out related to things that did not really take them to the doctor's office triggering an ICD-9 Code so that we could use that.

So we had to get some way to find out what was going on with them in between these visits, which we hope are very rare, to a doctor or to a hospital. And lastly, the traditional PPIP effort out in the civilian world at that time said, we need to do better at delivering clinical preventive services. We had a quality management review right at that time to give us a baseline and this is what it looked like.

So this is the quality management review of the civilian external peer review program which looks at DOD for a variety of colostectomy, c-section, a variety of efforts. This is the first time they did an out-patient review. Clinical Preventive Services and Military Health Services during that time looked at a variety of things, two-year old shots, cholesterol on active duty, paps on active duty, mammography and then counseling for alcohol, tobacco and STD's.

And what you see across the top is helping people 2000 objectives. The NCQA at that time here was two-five average for the civilian HMOs. And then what DOD did. Even though we reviewed 22,000 records in this evaluation and we had them

stratified by service, by tri-care region, there really wasn't any difference. So I've lumped them all together in that slide. And you can see that we did okay. But our job is very strenuous, very demanding and okay wasn't good enough.

And that's really what it came down to. What we really did bad on or our greatest room for improvement is in counseling. If you look at those, we didn't do very well at all. But civilians were not being at any of those at that time and that's why there's nothing for NCQA. Now one of the HEDIS measures is advising tobacco users to quit. So then in 1998, this is what MHS finally set, a policy. This is what you had to do by April, '99. So, a few months ago.

You had to have 2766, the prevention flow sheet summary of care problem list. You had to do a HEAR. Now the annual HEAR has been suspended pending deployment of the automated HEAR, but you're still supposed to have one upon enrollment, review immunization status and to address prevention at every visit. So finally there was a policy. There was no software to support any of this stuff. What the civilians had found out is they were testing PPIP

in a variety of civilian facilities was that you really needed to have automated support.

Clearly the stuff was too complex, not only for shots, but all the rest of it. So what were we supposed to do. Well, PACA was supposed to integrate and track medical preventive service information using evidence-based prompts. So really guidelines are the point of care which still today, this is one of the few applications that does that. So why didn't we do HEDIS live clinical indicator reports rather than doing what civilians do and paying outsiders to essentially come into your HMO and do this for you.

We said we ought to give the ability for people, really anytime they want to, to take a look at how they're doing it on these quality measures. To automate the prevention flow sheet instead of writing them in which is the way we had done them in the past. We wanted to have the automated HEAR. I know you all have talked about the HEAR several times over the past couple of years, but we really needed to expand the scope and the breadth and the depth of the HEAR. On a paper-based format you really can't do that very well.

They skip patterns and you get bigger and bigger sheets and you get more and more bubbles and if you don't do this, get to 48 and you're trying to find out what's 48. So we said we really need to automate it so that the skip patterns are built in and you only see one question at a time and there's no numbers. So it's what's remarkable is people take the HEAR, which they've been doing now for over a year, the automated HEAR, then they have no idea how many number of questions they've answered, even though they've answered very, very many. And it goes very quickly. You only see one question at a time and the skip patterns are still thin.

And lastly one of all those MHS goals are the things that we're supposed to be doing, Goal 6, is information integration, not clinical, all the top ones are clinical. So what really does it do? Well, it goes into CHCS, which is our information system really supporting ancillary services. It grabs lab, pharmacy, demographics, radiology results that are appropriate to those things in the U.S. Preventive Services Task Force.

For clinical preventive services it goes in and grabs, even though there's this big monster

database of all this stuff in CHCS, it says I know I'm going to look for particular things. It's going to go into our immunization tracking software that we have and also the DEERS are a repository for active duty anthrax immunizations. So it goes and it grabs that information off the HEAR. The HEAR can be up to 200 questions. Those questions get summarized into behavioral risk factor categories, sedentary, smoker, overweight, mental health problems.

It summarizes all those and it brings all that information to the screen. Then that integration information which is a very daunting task, if you ask any civilian managed care organization. I don't think anybody here is from a civilian managed care organization, are they? Okay, where are you from, sir?

DR. LAFORCE: Rochester, New York.

LTC. FONSECA: Rochester. Well if you tried to integrate off a Legacy system, which is what this was. All these variety of studies, most people just give up right then and say, can't do it. But then what the real beauty of that is to take that patient's specific information and then bounce it off the knowledge base. And what we've done is to take

the task force's book and build algorithms behind every one of the recommendations.

And that's if we take that patient's specific information based on age, sex and military status and bounce them off here to generate recommendations that that person needs at that particular time. And it's delivered at the point of care, which again, we feel as others have written about extensively, that unless it's right there at the point of care it's too hard to do.

If I have to look it up somewhere, I don't, it's too hard for me. I have 15 minutes to see a patient. And then he gives these clinical summaries. And after that recommendation he tells you whether something is due or overdue and it tells you if it was a test, like a cholesterol value and the lab says it's abnormal, it's abnormal. Frequently what's also done is if you have an information system where it has a lab value of total cholesterol of 180, it will give in the exact same format that you had from your lab.

But again, since we want to integrate, summarize and translate, the first translation we do is it is normal or abnormal. Again it's because most

people, most docs want to know right off the bat because the person is there because they have a rash or a cough or a twisted ankle. They are not here for prevention visits, they are here for a sickness visit. So we do that, we summarize behavioral risk factors of the family history, the climate, conditions and we can view it at a glance using red, yellow, green.

So all these overdues and abnormals are red. Green means I know it and okay. Yellow means there's not enough data on the person to generate a recommendation to make it red or green. That's what yellow means. And then it gives you these reports. So this is really what it looks like. Everything across the top is patient-specific. The yellow is service delivery. Something that we did. So again, you see that CHCSIT are the shots.

The clinical tool, DEERS, is shots repository. That's the only two-way communication. It can write to DEERS, everything else it just reads from. So yellow is service delivery specific to the patient. Blue is the patient-centered information. Only I can tell you my behavioral risk factors. And right now I'm the only one who can also tell you my

family history.

So blue is patient-specific but patient-centered information. Yellow is patient-specific service delivery and green is the knowledge. And that is the guidelines that are there for everything in the Task Force's book and then we summarize it on the screen. So where are we today? For the Army it is now deployed at six sites. There's nine more to be done this year.

For the Navy it's at nine sites, eight more to be done this year. For the Air Force, it's at 19 sites, eight more to be done this year. Now the real issue is CHCS II, the son of CHCS I, is supposed to provide this prevention functionality. Now the real question of, for everybody to day is will it? And will it do it adequately? Meaning both will the quality and the timeliness come right now?

Right now PHCA stops deployment in November of this year, just a couple of months from now because CHCS II is supposed to deliver this functionality. Well as usual in development the time line has slipped. And so we've got to go several months at the shortest to three years on the outside with no more prevention support besides those 15 Army

sites, 17 Navy sites, 27 Air Force sites. And is that good enough? And that's something that the services and the MHS are going to have to deal with.

The people that have it say things like this. We just started this in February at Nellis. This was a facility, real fighter-type Air Force Base that had done terrible on its prevention activities before this. Which is why the Commander was so motivated to get it squared away. They said, "We're going to do better." And that's just what they did. And you can see for just the medical readiness part what these guys were able to do and this was one of the worst performing bases before.

But when you give them automated support and the Command incentive to change your clinical processes, these are the things that can happen. Without it, people go, well, it's just impossible to do. This is Nellis' slide. This is what they say it does. So it's not that, not only that it's a great idea and a good piece of software, but it creates real change. So it has definite impact.

Same thing at the Army sites and the Navy sites that are using it. We really need to figure out if we really mean what we say that prevention is

important and that delivery of health and fit and ready forces, while what we're all about is Job One, how are we going to do it for these remaining sites? And that's just a screen shot so you can see what it looks like.

And this is where, the bulletized version. I've talked to a couple of people on the Task Force if they could, bullets. You know, so when you open up any chapter it has just the summary, the text and then clinical intervention. And yet, if you had one more summary somewhere, the bullets. When we first delivered it to providers, we did it verbatim, the recommendation verbatim. The clinical intervention, they said give me bullets.

So tell me if it's cholesterol, just tell me that it's 45 to 65 for women, men, 35 to 65, that's what we want to know first. And clearly that was a lot of work for us to bulletize all of those, but we did it because that's what they told us they wanted. I don't want to read lines, give me a bullet. And so that's, that's what we've done. And that's really all it looks like.

Everything else is, again, it's at a glance. And if you want more information, you double

click it and then you can see the details of the cholesterol, whether they are abnormal, whether they came from a lab or was it historical information. And it's, I'll be working off of there. One screen and drill down if you want to see more. So if you look what that screen was before, behavioral, personal history, chronic conditions, family history.

And the way that we did it so that you don't have to do a whole lot of screens, is that this is adding a chronic condition. And we just have a variety of systems and we have cardiovascular. You pull it up and it pops up to a variety of heart disease, with a second pop up. And heart disease, what kind of heart disease? CHF, Coronary Artery Disease, Arrythmia, a valvular disease. And so really on one screen you're not having to learn a whole lot of things, you can just drill down and pop up more and more things. And that's it. Are there any questions? Yes, sir.

DR. LAFORCE: Let me get this straight. You've been developing the PHCA to integrate Preventive Services Task Force Guidelines for all of the military?

LTC. FONSECA: Yes, sir.

DR. LAFORCE: At the same time CHCS II was being developed and both of them come on line at that same time or about the same time and you're going to do away with this?

LTC. FONSECA: Well, originally --

DR. LAFORCE: Oh, no, is that, do I have that right?

LTC. FONSECA: Well, you have it right today.

DR. LAFORCE: Thank you.

LTC. FONSECA: Originally this was a module of CHCS II. So in the first CHCS II plan there are several modules. This was the prevention module of CHCS II. Now we just, we stayed more on line, even though our time line slipped too, it only slipped by a couple of months. Theirs has slipped for over two years. So we came out, even though we were supposed to all come out at once with a comprehensive package, we stayed at our time line and we beat the other guys, so this came out two years before the rest of CHCS II. Subsequently, CHCS II has taken an entirely different path.

And so, yes, today you're exactly right even though that was not the original plan.

DR. LAFORCE: So this may be a huge waste of effort.

LTC. FONSECA: It will be less of a waste of an effort if we still deliver this to everybody that wants it and I know the Navy and the Air Force submitted a variety of MTFs on Friday to continue deployment and modifying. What we've done is we have helped, myself and others, have helped CHCS II to scramble and provide the same level of functionality. So it's not entirely rusty, but it's not at all complicated.

DR. LAFORCE: The other issue is when you talked about the success at Nellis, I noticed that the success related to laboratory testing, do you have data in terms of tobacco, alcohol and have you had commensurate increases --

LTC. FONSECA: Great question. Do we know when the follow up from our PPIP is due out?

PARTICIPANT: At the end of this month.

LTC FONSECA: Okay, again, we have outsiders coming to do this review. It's part of the quality management review. Our PPIP sites, Army, Navy, Air Force, outside review. Again, records reviewed, looked at. So we could provide it

ourselves, but we know that the civilian outside group is going to ask and already surveyed us about four months ago and now we're providing that document.

So rather than us telling us how well we did, we're going to let the outsiders produce this document which, you know, due right now and then we'll be able to tell you exactly what we're doing for a variety -- a lot of that is counseling. A lot of that is around alcohol, tobacco and STDs that we in the military suffer relatively disproportionately from since we don't have the other usual, when you haven't been able to find all that time.

This is just the readiness one which is what has been shown at Nellis.

DR. LAFORCE: May I ask how much this cost?

LTC. FONSECA: I have no idea, since I'm just a doctor.

DR. LAFORCE: But what would you think? Tens of millions?

LTC. FONSECA: No, I would say, I would say that, no, I would probably say in the range of five million dollars to develop it and deploy it.

Unfortunately in DOD when we deploy these things we have to provide all the hardware too. So over half of that are the desk tops and the servers and the communication. So when we do it different than a civilian organization, you would never want that infrastructure and the software at the same time.

The software alone was only about a million dollars.

DR. LAFORCE: Well, the reason for pursuing this a little bit is there must be, within the U.S., on the private side, the health care industry within like the Puget Sound, VIA Health, Wisconsin's got one, there must be ten of these that have been developed to do exactly what you're describing right now. And in point of fact using almost, I've heard these words before in almost the same way.

Without numbers, sort of bulleted, that sort of spin out, you know, the red, the green, the yellows, etcetera. And it's the, it's the parallelism that strikes me in terms of whether these were in HEAR already available or was there enough uniqueness within the military in terms of its applicability across all the services that really

makes this a really, a useful project.

LTC. FONSECA: That's a very good point. But since I, I'm a preventive medicine doctor and I've been living in the informatics world for the past couple of years, Dr. Tom Thompson from Group Health came out to see our show, shop two weeks ago - -

DR. LAFORCE: And he likes it?

LTC. FONSECA: Because it doesn't exist. Not even in Group Health Cooperative in Puget Sound and I'd like to see whatever it is. This does not exist anywhere. We automated here alone, even though you can buy it now from the same guys who sold it to us. We automated here alone because it exists.

DR. LAFORCE: Do you have any sort of patent? Can you sell this?

LTC. FONSECA: We don't own it.

DR. LAFORCE: Oh, you don't own it.

LTC. FONSECA: No. A lot of this stuff are modules that we bought. The core piece we do own, we do own. The federal government, as you may not know, cannot have a copyright to anything; everything we do is in the public domain. So that if we can enter into somebody else, that they can come

and grab it, you're exactly right. And so there is, and that's why VIA Health wanted to come see our's. Because they said, we haven't figured this thing out yet, we kind of mooched conceptually off of Northern Kaiser of Northern California and let them figure it out and then we'll come and feed back off of this.

But yeah, the work that we've done and paid by your federal tax dollars is probably 90 percent for anybody to come and pick up from there and finish it on top of their Legacy information system. So it's definitely not wasted dollars in terms of technology transfer.

DR. LAFORCE: Please, don't get me wrong. I didn't want to intimate that it was wasted.

COLONEL DINIEGA: I have a comment. I have two comments actually. One on what you say about the civil course and then I have a question for Dr. Fonseca. In the mid '90's when PPIP first burst into the scene and there was a big push to implement at the public health and the state levels, etcetera, etcetera. The military decided to look at implementation and they started off with a very huge endorsement conference that we had here in D.C.

The Office of Disease Prevention and

Health Promotion at that time had not automated PPIP and were going to. But the push was so heavy in the military that we couldn't wait for automation of the national program as was proposed. And so we went ahead and looked into ways of automating it ourselves. Because it was going to be a considerable burden upon the clinical providers out there to implement a good PPIP at the primary care level.

DR. LAFORCE: My point is that with all the work that you've done, that whatever national conferences are going to occur in terms of Health 2000 conference or all of this, that I think they would welcome this presentation particularly if everybody who heard this knew that there was no copyright and it was freely available to anyone. I mean that would be maximizing distribution and doing something that I think would be incredibly useful.

COLONEL DINIEGA: And that can be tied, you know, Ms. Maiese, Debbie Maiese yesterday talked about more coordination and cooperation between DOD and her efforts. So that can be done and I can give Colonel Fonseca her number and let them talk. My question to you though is, at one time Dr. John Grundage, who has now retired from the military, when

we were implementing PPIP in the Army had come up with a very nice acronym, PPIR, Put Prevention Into Readiness. And you started out by saying this has a lot to do with readiness.

PARTICIPANT: Main driver.

COLONEL DINIEGA: My impression goes one step further. The support of readiness is in predeployment, primarily. My question is, as when they deploy, and if they're in theater and then afterwards with a lot of questions on the post-deployment, how can the PHCA and its contents be used to help our forces and force protection during deployment?

LTC. FONSECA: Well, as Dave Trump knows, that before those questions used to be far greater. And the reason why they're the small number that they are is because we said, because exactly that. All this stuff should be day in and day out, normal business, pre and post-deployment. And by delivering this up two in a question here, day in and day out when you're ready to go, I'm only asking "Do you have any medicines, are you pregnant?"

And so that's really the biggest impact on minimizing your preparation for deployment work,

because the, actually the pre and post-deployment comforter is also in the automated here. But the new value is by asking the bulk of it under normal circumstances when I'm getting ready to go to Kosovo or wherever.

PRESIDENT PERROTTA: Okay, let's take them in order. Dr. Atkins, Captain Schor, Rosie, Dana, Traffic Cop.

DR. ATKINS: I mean this is an issue we grapple with at the Task Force because I think we've recognized that it's these systems changes that are actually going to get stuff done. And I guess the question I had was, what you had to do to develop it. Part of it was translating our recommendations into workable algorithms and so that's a fair amount of work.

The second part is the software of getting it to talk to your information system. And my sense is that's the stuff that wouldn't be transferable to a Group Health because their radiology database might use a different --

LTC. FONSECA: We're using the standard HL-7 messaging. So we're already using the existing health care informatic standards to do that. So I

couldn't drop it into Group Health or Rochester, New York and it would work automatically. But HL-7 messaging is already there, we just need to find out where they store it. So most of it is transferable.

DR. ATKINS: So depending on how centralized the information systems are in different plans you could, the translation part might not be that --

LTC. FONSECA: It might not. And then even more importantly, in Texas for example, since we happen to be in Texas, we've gone to their PPIP conferences for the past three years, where you don't have an information system in a public health department for the most part at all. But they are trying to do prevention at the clinics. So, and they're happy, I mean they could use it today because they have no information system to grab it from.

But they do have people writing things in pieces of paper and they'd rather have that person spending the time keying into the information instead of reaching and grabbing. Because then you get all the other benefits of it. And so they're ready to take it today because they already have clerks handwriting things on prevention flow sheets. So,

and the public health department, because of their lack, it's when people are getting ready to spend millions of dollars on a Legacy system, yeah, they're saying, wait a minute.

I'm going to have to make sure I leverage that information on your pay form. Public health departments are going to say, hey, give me right now, because I don't have a multi-million dollar Legacy information system.

COLONEL BRADSHAW: The other comment to your question, though, is that, the effort that we're doing with CHCS II which uses a 3M product that has a lexicon and everything else built in and it's currently being used by one large HMO, the Intermountain Health Care, we're trying to put PHCA functionality into that system which then anybody can buy essentially, I would think, at least the underlying, you know, information which with the 3M product. So that might even have a different type of broader application.

CAPTAIN SCHOR: Let me just, I would like to raise a concern from the Marine Corps perspective and bring the discussion back to an operational perspective. And this is something that's very, of

great concern to my boss, Admiral James Johnson, and also the Marine Corps. And that is the issue of operational support at deployability.

This is a great system when you're in a fixed hospital, a fixed, robust, full-service clinic. Marines don't work that way. The Marines have battalion aid stations. They often, if they're lucky, have a 486 computer. It's not linked to anything. They might be linked to CHCS. And, oh, by the way, we deploy a lot. We deploy on ships. We deploy to Kosovo, to Turkey and to all those things.

We're supporting that from base stations over the horizon, 25 nautical miles off shore and up to 150 nautical miles off shore. And doing things on land and projecting power shore. The concern is, this is wonderful, this is fantastic. I can get any Fleet Marine Force Corpsman to do this and make it work for his squad and his guys and can make it work.

The problem is if it is not linked up to CHCS, it doesn't help us. It doesn't bring in those lab results. It doesn't enumerate all that stuff. And so our concern is that we need to have something that is integrated with line information requirements that is accepted by the line military. This is not

at this point, as I understand it. And that is transportable and we can put on a lap top, that we can take out there.

And when you're spending ten days going from North Carolina into the Straits of Gibraltar going into Sixth Fleet and give your completed submission there. Ten days going across the Atlantic is a great kind of duty for preventive health care. So my caution is, is that all these things are wonderful and I assume this is going to be a rising concern for the Air Force as you go to Air Expeditionary Air Forces.

This stuff has to be transportable to reach those who are, who military medicine is really serving and that is the active duty Soldier, Sailor, Airman and Marine.

LTC. FONSECA: Well, like I say, the Air Force now for the past two years deployed more than anybody. And by automating your day in and day out stuff while you're in garrison and printing it out on 2766, that is what deployed with the person. And since we're not doing more for operations other than war, where there's not bullets flying for the most part. In the last one we were talking about bombs.

But when you came home you were relatively safe sitting in Avellano Air Force Base in Italy. And you're exactly right. It's when people deploy now and since it's not bullets coming at them, there are the one full health promotion time. Everything has changed. They don't have work, the don't have a babysitter, they don't have kids, they don't have all those things going on right there and then. Actually they relatively have a lot of free time on their hands because there's nothing to do where they are.

When I was in Haiti, for the most part people, I started smoking cessation because people came up and were saying, gee, might as well try quitting smoking since I'm sitting here. So you're exactly right --

(Laughing and talking.)

DR. SOKAS: This is just getting back to what Colonel Diniega was already saying and you've already mentioned. But I think it would be incredibly important to have a lead PHP have access to this, take it and make it readily available. So just to make sure that link happens.

LTC. FONSECA: Yes, actually a couple

people from ODPHP and HHS are working with us on our next improvement of the automated here, so we have some people liaison, PHS people who are liaisons with them. Dr. Mary Pachiro and Betsy Thompson of CDC.

COLONEL BRADSHAW: I'm just going to respond back and then you'll be next. On some of the things, just adding on to what Benny already said but part of the issue is that it has been identified with the Navy in particular and Marines by inbreeding or whatever, I don't know.

(Laughing.)

COLONEL BRADSHAW: No, I have the same problems, basically, as there is some differences in the way they do medical records. Currently the Army and the Air Force, actually since the Gulf War this started, actually, use a deployable medical record. The medical record does not go with them. There was this plane crash where there were 200, you know, of the Army folks killed along with their medical records because they had them with them.

And so we have a deployable medical record, well part of that is this DD-2766, which is the adult preventive and chronic care flow sheet which basically has all this individual medical

readiness, problem list and it also has immunization tracking information and a lot of other just core --

LTC. FONSECA: TB skin testing?

COLONEL BRADSHAW: Yeah, core information that's needed. And it's actually in a very hard, you know, cardboard backing thing that would originally go around the medical record. The Navy and Marine Corps take their entire records still because they keep it on board ship. But basically the PHCA is designed where it can print out an entire DD-2766, all that core information.

And that's also the kind of information that goes on the personal information carrier that you heard about yesterday, which is whatever this electronic dog tag. And so I think we in the military, we're already moving toward it but we're also, need to probably do some more to say what is the minimum information that needs to go back and forth between all these systems. So in garrison, we need to carry some of that in garrison information to the field or to the ship and there needs to be a minimum core that can go back and forth between systems.

So when the Marines or the Navy folks are

in port or in garrison, that they get that information updated, that's when they get, you know, some of their stuff done. But there's also minimum stuff that can be collected on ship but should pass between all these different things. So I think that's part of the solution, but we have identified that not only the Navy and the Marines need a stand alone system, they can share information back and forth or update it periodically, which is more kind of what they would need to do.

But also our Reserves and our Guard units need the same kind of thing. And it needs some of the same sort of information. So it's something that I think as a common solution issue for the Guard, the Navy and the Marine Corps.

LCDR. LUDWIG: Yes, I'm Sharon Ludwig from the Coast Guard. Commander Tedesco is not here today. We have actually the same issues as the Navy and the Marine in terms of the need for portability and we have a lot of very remote sites that would also need the portability. The issue that I wanted to bring up too, though, was that one of our big concerns right now is tracking the anthrax vaccine. And we're currently using the Navy system, the SAM

System, which is marginal in its benefit for us.

But we chose it because it was portable and it's what the Navy used. But in any case, we were looking into the options and we thought we were going to go with the immunization tracking module of PHCA, because we wanted to be on line for whatever the DOD was going to use ultimately and we had understood that was going to be it. We were already, we even got the money allocated for it, which was an amazing thing.

And then we found out that the DOD was not going to be going with it. That it didn't satisfy the functional requirements for immunization tracking for the other services. Do you know, can you comment on that?

LTC. FONSECA: Yeah, what I would say is if, especially for the Coast Guard concern about portability and low cost, I would say talk to the Air Force MTS guys because of it's lap top availability and it's free.

LCDR. LUDWIG: Right. We're working on it, but I'm just wondering if, what's going to happen with the immunization tracking?

LTC. FONSECA: The CHCS II, they still

have not decided. Dana and I were there last week with, talking again functionality again like we are doing for shot software. However, we do know that MTS works with PHCA and PHCA data will be incorporated in the CHCS II when it deploys. So for MTS, you can get to whatever happens at the end of CHCS II.

COLONEL BRADSHAW: I'll try and help answer that. As Vinnie said, apparently some of the issues on moving the RMS, the enterprise immunization tracking module, part of it was when they were looking again at CHCS II, is there was some technical issues. It wasn't just functionality but there were some technical issues in trying to migrate that product on over.

And they basically, we were told at least for sure now, that that is not going to happen. So a lot of that is really the CHCS II. So again, there are going back to saying we can do the same functionality within our system, we have that capability. Just tell us what the functional requirements are and we'll program it in. So that's basically what we spent time doing last week, is making sure those functional requirements were in

there of what we currently have, what we think we would need and make sure that we don't lose anything but that it's integrated right into the CHCS II system.

Now where that leaves people is that, I mean RMS is built into the current PHCA module so you can still go with that but what most of the services do and are continuing to use the Legacy systems and I would just recommend that maybe you have the different services, you know, I mean you already know what the SAMs module does, but you may want to look at MTS. MEDPRO is, the problem I think with it is it's very tightly linked to a central server.

So the MTS maybe the better solution for you if you're not satisfied with SAMs. And I would encourage you to get Colonel Williams because it does have stand alone capability. All three services, tracking systems upload to DEERS, which is the common repository. So any of those, you know, every one of the systems will go to, you know, talk to and get information from that central system. So really it's just an interface. What you want is a front end for you.

LCDR. LUDWIG: Yeah. Actually we have,

we have a different interim solution, but, I mean we looked at all those possibilities. One is we have some different software for our personnel site at the house and so we had to come up with a different solution all together. But it's still an interim solution. And what I was mostly interested in is long-term what's going to be happening with immunization tracking.

LTC. FONSECA: They've got to develop their own.

LCDR. LUDWIG: And it's going to be part okay, so it's going to be part of CHCS II but the one that's in PHCA now will not be --

LTC. FONSECA: That's correct. In the ultimate CHCS II, when that will be delivered, again --

COLONEL BRADSHAW: The common, the common denominator is DEERS, because that's the repository for all DOD, you know --

LCDR. LUDWIG: It is for us too.

COLONEL BRADSHAW: -- enterprise immunization information.

LCDR. LUDWIG: Right, our's is.

COLONEL BRADSHAW: So whatever you do,

you've got to make sure it talks to and gets data out of DEERS.

AUDIENCE MEMBER: I just have a question. The Navy has spent a great deal of money deploying clinical epidemiologists to do a lot of our MPFs in order to be able to do population-based analysis. And my understanding is PHCA at the present point won't allow us to do that. You know, it's still just individual-based. Is there any, and is there any discussion to have this so that there is some way that they could drill into the information and query the actual population-based analysis for trends on immunizations, trends on, you know, you know, counseling and so forth?

LTC. FONSECA: We can get that today. I don't know what, yeah, I mean I don't know what you mean that you can't do a query on the -- where are you?

COLONEL BRADSHAW: You're talking about at the local facility or central?

AUDIENCE MEMBER: At the local facility.

LTC. FONSECA: Yeah, that's what I mean. Where are you that you think that you can't do that?

AUDIENCE MEMBER: That's what I

understand is --

LTC. FONSECA: No, that's not true. Talk to the, I guess Corpus Christi is the one that's had it the longest. Talk to guys there. Talk to Captain Gorpy at HUMED, Mr. Jim Walters at NIMIT. They will be able to tell you exactly what you can and you can't do. But there may be people who have to deal with these prevention issues at HUMED and at NIMIT clearly understand what it can and can't do and that's why they're pushing, just as the Air Force is.

I'm not sure what the Army's position is on those additional deployment sites.

COLONEL BRADSHAW: You should make a distinction and it may be where this confusion is getting in. But you can get local aggregate reports. So for instance if you want pap smear data on people at your local MTF, as long as it's in CHCS I, you can get that aggregate information and you can develop the ERISA reports. You can do a query to carve it up any old way you want to and do all the analysis you want.

The difference is that it's not currently, because CHCS I is a local system, it's not aggregated centrally. It will be in CHCS II because

CHCS II will send all its data up to regional and central servers. So once that functionality is in CHCS II, you can get aggregate data centrally. But a local MTF, as long as they work with the ERISA reports, can get any kind of report out from any kind of data that's in PHCA.

LTC. FONSECA: Well actually it doesn't matter what reports are already used. Because again it's an OUC data base. It can use any of these, access any --

AUDIENCE MEMBER: Right, but the other thing is you can't get, you won't be able to get aggregate data for like HEAR information, direct from the PHCA.

LTC. FONSECA: No, you still can. If you're a clinical epidemiologist at Bethesda or Corpus Christi or San Diego, it doesn't matter where. Because of the structure of that database you can use whatever report, query tool you are comfortable with, SEQUEL, it doesn't matter. It's an OUC database. And that's your clinical epidemiologist had, you can invoke exactly, try to get prime beneficiaries. Talk to the guys in the Navy. Back to you.

PRESIDENT PERROTTA: Okay. Well, our Consultant has shown up but I think, just because we went through all the angst of figuring out a new schedule, let's stick with the way it was stated this morning. Is that all right? So can we call the Executive Session to order?

PARTICIPANT: Yes.

PRESIDENT PERROTTA: So called. I have a list of about one, two, three, four, five or so things.

COLONEL DINIEGA: I have some announcements.

PRESIDENT PERROTTA: Colonel Diniega has some announcements.

COLONEL DINIEGA: Yes, just a few reminders for the Board Members. TTY settlements, when you get back, get that into Jeanne. And also she'll be sending out calendars for the projected months for the future meetings. If you can send in your, I think she always asks for and you can ask me for dates you are not available. And then we will be able to see when we can get the majority of the people together for a meeting.

The next meeting will probably, we're

looking at maybe a February time frame away. And it's the, we had skipped over the Army's turn for the away meeting, so it will be the Army's turn this time unless they pass. And once we have a date set we will be able to let people know where it will be. It looks like we will be having four meetings a year, rather than three.

I think it worked out better when the BW-3 review was held separately for a day, and all we had to do was concentrate and focus on that one subject. We can follow your agenda.

PRESIDENT PERROTTA: Okay. Let's talk a little bit about the Committee or the Board and who's going off and who's coming on. Looking at the updated list from the sixth of August, as best as I can tell we will have five people rotating off now and then one rotating off in November. Dr. Barrett-Connor is rotating off. Jerry Fletcher has. Dr. Poland and myself and maybe even Dick Jackson, even though the numbers are a little bit odd here.

My suspicion is that he does. And then Julian, Dr. Haywood is, will rotate off in November. So that leaves us, one, two, three, four, five people, maybe six people that we will be down this

year. And so my thanks to everybody on the Board and on the PMO side who have made some recommendations about new members.

COLONEL DINIEGA: Oh, on the Board rotations, Dr. Barrett-Connor is being, is in the process of being renewed --

PRESIDENT PERROTTA: Okay.

COLONEL DINIEGA: -- for a second term. And so is Dr. Haywood.

PRESIDENT PERROTTA: Okay. But that's, yeah, well, that's the odd thing. Because we've got Julian down for a three-year period here and that didn't make any sense to me. So maybe he has another year. So we have added, a lot of people made great recommendations. My understanding was is that the Preventive Medicine Officers and Ben visited about all of this and made some recommendations and the selections that have been made will include five new members, probably at the next meeting?

COLONEL DINIEGA: Yes. There were 14 nominees, all of expert quality. And the Preventive Medicine Officers held a meeting and their direction was, their choices, since the Board works for them, and it had to be unanimous, they had to agree on the

selections. And they selected five new members that Dennis will mention. But the process takes, on the short side, three months and on the long side, six months, with all the forms, etcetera and reviews that we have to go through. Hopefully, they will be at the next meeting.

PRESIDENT PERROTTA: So these five, hopefully, will be at the next meeting. And is it my understanding that some of the others that aren't on this list might be on, essentially a que that you would consider with new folks coming on or leaving?

COLONEL DINIEGA: Yeah, what the Preventive Medicine Officers recommended is that we keep the people that were not selected this time, you know a pool of people and add new recommendations to that pool.

PRESIDENT PERROTTA: So the process may be shortened. Okay, for the Disease Control Committee there are three new people, Steve Ostroff, a physician who is, his real title is Deputy for the National Center for Infectious Diseases. He currently is sitting in Claire Broom's office as the Deputy Director of CDC, while Claire does some special work. Dr. Phil Landrigan who is at Mount

Sinai and is well known in Environmental and Occupational Health.

Bill Berg, formerly of the Navy, who is Health Department Director at the Hampton Health Departments. Dr. Pierce Gardner from SUNY at Stonybrook will be added to the Disease Control. And Linda Alexander, who is with the American Social Health Association will be added to the Health Promotion and Maintenance. Steve Ostroff, Phil Landrigan, Bill Berg, Pierce Gardner, Linda Alexander. Okay? So again my thanks to those of us who are, my thanks to us who are rotating out.

COLONEL BRADSHAW: We would like to add our thanks too, especially --

(Applause.)

PRESIDENT PERROTTA: Okay. So, since the President is one person who is going to be rotating off, it's time to make another election or selection of President. And hopefully the Board Members got an e-mail from me and I received recommendations and inquiries and hopefully was able to answer those inquiries and took those recommendations. And what I think I'd like to do is, is make a nomination based on that e-mail set of recommendations and then open

the floor to any other Board Member who has either want to nominate themselves or nominate another Board Member.

Again, I would recommend that it be somebody that, again, because it was an e-mail, that it be somebody who's got more than a year left, maybe two years left on the Board. And somebody who's been able to make this enough of a priority to be here. And as we all know, we travel too much and so we understand that. So based on, is that an okay process for everyone? Is that all right as a process?

DR. ANDERSON: So moved.

PRESIDENT PERROTTA: Okay, well, right. Good, I get to do that again. So based on the nominations and based on the discussions I've had on the telephone, I'd like to pose Dr. Mark LaForce as being nominated for the next President of AFEB. And I'd like to ask Dr. LaForce to now affirm whether or not that's okay by him.

DR. LAFORCE: Yes.

PRESIDENT PERROTTA: Okay. And then open the floor to any other nominations by Board Members.

(No response.)

PRESIDENT PERROTTA: Okay. Hearing none. That's right, tick tock, Art needs to catch a plane. Hearing none, then I think we have, does anybody feel like we need to vote for Dr. LaForce? Let's hold a vote. All those in favor of Dr. LaForce as the new President of AFEB, raise your hand? Anybody voting against? None noticed, congratulations very much.

(Applause.)

(Asides.)

PRESIDENT PERROTTA: Okay, I'd like to make a brief report on behalf of a special Subcommittee that was formed at the request of Major General Claypool to review a document about this thick, put forth by the RAND Corporation. I've got a copy if anybody wants to take a look at it. And I think you're all going to get a copy anyway. On a review of the scientific literature regarding the potential role of pyridostigmine bromide, a nerve agent pre-treatment in illnesses of Persian Gulf War Veterans.

The General asked me as the President of the AFEB to join with at least three Consultants from this university here in reviewing this document and

bringing folks together to discuss it and make recommendations. Basically, this document reviewed the scientific literature and regarding the potential that this may be related to some illnesses and the document actually also posed some theoretical possibilities of how this may occur, if it in deed occurred.

The Committee that was formed was graciously, and they allowed us to snag some of their time. The document was difficult to read and so I appreciate the work of Dr. Henry Anderson and Stan Music of our Environmental, Occupational and Injury Subcommittee and myself to, who helped me work on that along with three physicians from USUHS in Anesthesiology, Neurology and Pharmacy -- Neuropharmacy. So these guys are really good and they helped us understand a little bit about what the document was talking about, some of the pros and the cons.

My understanding is that our review of the document has been written in rough form, we're waiting for two more, two of those physicians from USUHS to give us their input. It's been a very flexible and fluid process as to timing. My

understanding is that Secretary Bailey wants a copy of that report, a copy of our report in her hands before the end of this month, by the end of this month, which is about when the RAND Corporation is going to release the document.

So she'd like to know what her Board here says about the quality of that report and the recommendations for further research. We also reviewed a moderate sized list of the currently DOD-supported research on pyridostigmine bromide that's going on in universities and other places around the country. And we did that as well. I think the way that this needs to occur is that as a special Subcommittee we would bring our recommendations forward to you as a full Board and have you approve them or not approve them.

And it's, perhaps we won't be able to do that until the next meeting. And so what Dr. Bailey may end up getting is a draft report. I'm not sure how we need to work that as far as, is that okay. Once we're happy with it, we can send it to her and then we'll send it to everybody else and then there will be a final, Mark will hammer it down or gavel it down. I don't know exactly how that needs to work.

COLONEL DINIEGA: Once the report is released, we'll be able to get copies of the RAND Report to all of the members so that they can look at the Subcommittee report and also if they need to refer to the RAND Report. So some time after the RAND Report is released, then we can get copies and we will send the RAND Report to all of the members. And then we will also send the Subcommittee report to all the members. And then we will look for approval at the next meeting.

PRESIDENT PERROTTA: Okay, Henry or Stan, do you have anything to add to the report? Okay, are there any questions about that?

DR. LAFORCE: What's likely to happen after the release of that report? What actually happens?

COLONEL DINIEGA: My understanding is the Office of the Special Assistant for Gulf War Illness has commissioned the RAND and, I don't know, other Contractors to look at various aspects of the Persian Gulf War illness and there are numerous volumes. This was involving eight --

PRESIDENT PERROTTA: I think there's like 15 different topics.

COLONEL DINIEGA: -- different topics and those reports were written for OSAGWI, the Office for Gulf War Illness. And the from there it should filter down to the surfaces for action. And Dr. Bailey was merely using the Board, or this Board, to consult with our Consultants on the AFEB, and implementation of any of the recommendations will filter down to the surface sometime in the future.

PRESIDENT PERROTTA: So there are some recommendations, for example, that we think are good and we would forward those as the Subcommittee supports these recommendations. And there might be some that we think are not so good and would be a waste of time. I wouldn't say anything like that, of course.

COLONEL DINIEGA: The other volumes, they have, I think, sent the draft or released the volume on Infectious Diseases during the Persian Gulf War and that --

CAPTAIN TRUMP: That's was just, that's still in the draft.

COLONEL DINIEGA: That was a draft.

CAPTAIN TRUMP: There have been published ones on depleted uranium, stress and it's relation.

They've dropped, the ones that are published are depleted uranium, oil well fire smoke, stress and one on, more on the, not on the science but on the issues of using investigation on new drugs.

COLONEL DINIEGA: And it's been left up to the services and health affairs and OSAGWI if they feel there is a need to consult with anybody else, then they will look at consulting. Some of them maybe goes to the medicine if there's issues that remain unresolved.

DR. ATKINS: Is that, why are we being asked to review this one document out of --

COLONEL DINIEGA: Because the Health Affairs wanted to get the Board input on the draft.

PRESIDENT PERROTTA: But why on this draft and not on the stress or any infectious disease?

COLONEL DINIEGA: Well, I think they felt that this was a little more difficult to form an opinion on. Some of the other recommendations in the other volumes are pretty straightforward.

DR. LAFORCE: Are there any others that are coming? I'm trying to figure out when that finishes.

COLONEL DINIEGA: Oh, to us? No. Not that I know of. It depends on who gets the report. You know the way the Board works, as we all know, is that Health Affairs can ask us to help them or the Surgeon General's Elite Service can ask us to help them.

PRESIDENT PERROTTA: Thanks. All you wanted to know about pyridostigmine bromide. I can even spell it now. Okay. As it, as many of you know, we've, we get assigned here for two years and if you like the Board and the Board likes you, they'll re-up you for another two years. But at the time when that occurred for Greg Poland and myself and Jerry Fletcher, a look at the Board composition there was, everybody else was brand new.

And so they, they allowed several of us to be re-upped again for a total of six years, which may or may not have been unheard of. And in those entire six years, every time and in the last year and a half as President, every time this Board needed some action on matters of disease control, vaccines, infectious diseases, we had a number of good people, Bill Schaffner and others, but there was always somebody either in the background or in the last few

years, in the forefront, of getting these things done. And that's this gentleman over here, Dr. Greg Poland.

And as the President of AFEB and as having a full-time job doing other things, the ones that pay my bills, whenever Dave Trump or other people or Ben would call up and say, we need to have something done about this, go to a meeting, have a conference, take a look at these adverse, vaccine adverse event records for anthrax, it took one telephone call.

And once I got a hold of him, being the busy guy that he is, I never heard the word no. And I can't tell you, and I hope many of you who have ever been in, I guess this is a leadership role, would know how important that is for a Manager or a leader to have somebody that you can reliably go to and get high quality products out of there.

So for the last few months I've been beating Jeanne Ward and Ben Diniega over the head and asking them if we could put something together in honor of Dr. Greg Poland.

(Asides and laughter.)

PRESIDENT PERROTTA: And you should also

know that a year and a half ago when they had the elections for this, Greg and I was up there, and I'm pretty sure that it was one or two votes that made the difference. So we would have very quickly or easily perhaps had shifted --

DR. POLAND: They wanted somebody that knew how to use it as a hammer instead of a gavel.

PRESIDENT PERROTTA: That's right. I can use it as a hammer too. So thanks to Ben and Jeanne for getting this to Dr. Gregory A. Poland, M.D., with needless appreciation for your outstanding contributions as a member of the Armed Forces Epidemiological Board from July, 1993, to October, 1999. Greg.

DR. POLAND: Thank you very much.

(Applause.)

COLONEL DINIEGA: Dr. Trump has something that he'd like to say.

CAPTAIN TRUMP: Not quite as pretty as the plaque, but certainly, and it's always hard to put into words what I think everybody here knows has been the contributions of many members of this Board, but we want to honor Greg in particular.

DR. POLAND: I thought you were going to

talk about Dennis.

CAPTAIN TRUMP: No, no. A certificate of appreciation to Gregory A. Poland, M.D. for exceptionally meritorious service as a Member of the Armed Forces Epidemiological Board from July 25th, 1993, to October 15th, 1999, as an AFEB Member and a Chair of the Disease Control Subcommittee, your superb leadership, excellent organizational skills, outstanding professional knowledge produced important policy recommendations for the Department's Infectious Disease Control and Immunizations Program. It is a contribution that significantly enhanced the health and well being of Soldiers, Sailors, Airmen, Marines, DOD Civilians and family members. Signed by Dr. Sue Bailey, Assistant Secretary of Defense for the Armed Forces.

(Applause.)

DR. POLAND: Well, I, you know, I don't know really what to say at a time like this, other than thank you. I should in part reveal that one of the reasons I do spend the time that I do and feel it's so important is that I'm from a Marine Corps family. All the males in the Poland family, since the time they have come here, have been in the Marine

Corps. My brother is still active duty, having just been promoted to Sergeant Major.

My father retired a few years ago as an Infantry Colonel. So it's selfish in a way because these things are very personal to me. They actually affect my family. And so even if that weren't the case, I think I'd take it seriously. But it does affect my family, so it's all the more serious. Maybe like General MacArthur I'd like to say I will be back.

(Laughter.)

DR. POLAND: That remains to be seen. Thank you very much, everybody.

(Applause.)

DR. POLAND: Now the table gets turned a little bit. When I was appointed to the Board, Dennis was also appointed at the same time and the then Executive Secretary of the Board was Colonel Mike Peterson from the Air Force. And Mike was a great guy, although I think he made one mistake and that is that he sat Dennis and I next to each other at most meetings. So we really became very close friends. It's amazing how quickly that did happen and have kept in touch regularly, through his recent

marriage and recently shared stories about how do I deal with my 13 year old daughter, which is new territory for me. The report was nothing compared --

(Laughter.)

DR. POLAND: But Dennis said some very kind words to me, but let me share some about him. It may not always be obvious to everybody on the Board and maybe people who may occasionally peripherally act to the Board, but Dennis has taken this job very seriously. He clearly was the right man for the job. I regularly get e-mails from him and I guess it's hard to impress upon you as individual members of the Board, how much thought and care Dennis puts into these things. How much prep work is done. These things don't happen by accident.

A lot of time and a lot of effort is put into that. Dennis has similarly produced, on much shorter notice than I did, important reports for this Board, so we have a little something for you Dennis too, with our deepest appreciation for your leadership. And it says, to Dr. Dennis M. Perrotta, with deepest appreciation for your outstanding contributions as a Member of the Armed Forces

Epidemiological Board, August, '93, to October, 1999.

PRESIDENT PERROTTA: Thanks.

(Applause.)

CAPTAIN TRUMP: Dennis, a certificate of appreciation for exceptionally meritorious service as a Member of the Armed Forces Epidemiological Board from August the 28th, 1993, to October the 15th, 1999. As a Member and as President of the AFEB, Dr. Perrotta's outstanding leadership, superb organizational skills, extensive epidemiological knowledge resulted in important policy recommendations and program reviews for the Department of Defense.

His contributions significantly enhanced the health and well being of Soldiers, Sailors, Airmen, Marines, DOD Civilians and family members. Signed by Dr. Sue Bailey.

PRESIDENT PERROTTA: Thank you.

(Applause.)

PRESIDENT PERROTTA: Some pretty technical stuff up here. Well, thanks very much, Dave and others for getting these things. I have just the place for them. Career and personal enrichment is what I consider that I've gotten out of

this, as well as a lot of new friendships. And I just want to thank everybody for helping learn an awful lot and listening to my monologues on occasion. And I hope that in my time, six years here and here in a little bit as President I allowed the organization to continue to grow.

And I would charge Mark and those of you who remain, as well as the PMOs and military colleagues, that this can be an important body. And everything you can do to keep it from slowing down, everything you can do to speed it up faster than we've been going now, I think would be useful. This is a time of extraordinarily important time for outside reviews, for careful consideration, for partnerships. And I think this has been a great experience for me and I hope you will continue to provide the service to the military and the personal reward that it has for me, for each one of you. So with that, thank you very much from me. Next meeting?

COLONEL DINIEGA: I already did that. February time frame with January as a back up. And the site is yet to be selected. So I just ask that if, when the calendars come out and we need, try to

do it by e-mail, if you can check your calendars out and send in those dates.

PRESIDENT PERROTTA: Okay. Would you like it to be in the D.C. area or --

COLONEL DINIEGA: No. The meetings previously, in recent years, have been, the winter meeting has been in December in D.C. We're trying to move it to February away in some place a little warmer and a little more balmy. The other constant is the BW threat list is usually released sometime in April, usually the end of April. And we called our meeting last time in May. So the BW threat meeting will be sometime in May.

So we will have two meetings or three meetings with the BW threat in the D.C. area and try to have the winter meeting away.

PRESIDENT PERROTTA: And it will be the Army's turn if they want it.

COLONEL DINIEGA: Army's turn if they want it. The new WRAIR Building is now, it's going to be formally opened October 5th, I think. I have a commitment from the Commander there that we can return now that they've moved. So that is one of the sites. You heard Dr. Zimble say that we're more than

welcome to have our meetings here. CHPPM has offered their site for the D.C. area meeting up at Edgewood.

Also USAMMRD has graciously offered themselves again to host meetings. So those will normally be the rotation sites we go to during the D.C. meetings.

PRESIDENT PERROTTA: Any questions about that? So I'd recommend that each of you do get that schedule stuff back as soon as possible. And if you have changes it would be great to send Jeanne an e-mail to update that, because perhaps one of the toughest things that we do is try to find a date where there's more than seven or eight of us that can meet. And it's pretty hard. Okay, everybody doing all right. My clock says a few minutes before nine.

Committee Chairs are you still okay with a 30 minute committee? Each one of you has been shown the room that you're going to be in, so why don't we move quickly and reconvene at 9:30. Sue.

PROFESSOR BAKER: Before we break, could I make two suggestions for the general group? Or would you rather have other business matters after our Subcommittee? One is, especially having seen

what Bridget Carr from the Air Force Center could offer us yesterday and would be interested in doing in the future, several of us have said it would be useful if each of the branches from their safety offices, if we had representatives from the safety offices.

I think Nick Webster from the Naval Safety Center, I mean there are other people in each of the safety centers who probably we could get a lot of benefit from having them here. My other suggestion has to do with the, with the agendas as they are printed up. I thought all of the presentations, I think, have been superb. But the fact that we really didn't have time to do justice to all of them or for, to have the extended Q&As that some of, you know, that might have been valuable.

If the agendas were printed in such a way that if there is going to be 20 minutes for a subject, we have, you know, General Jones at 9:00. At 9:10, discussion, so that General Jones knows that he's expected to wind up in ten minutes with an opportunity for the, and maybe a suggestion to speakers that they not have more than 20 slides or something that would allow the --

PRESIDENT PERROTTA: Keep us from having a 60 minute, 20 minute talk.

DR. SOKAS: Well, and just to emphasize that, maybe fewer talks even. Even though they are wonderful and you don't want to get rid of any of them. Or another options would be to make sure that each talk has questions embedded in it for the Board or that maybe some of them could be scheduled for the break out sessions as opposed to the whole group.

You know, just to allow more back and forth.

COLONEL DINIEGA: I think the initiative for this meeting, because the April meeting was so one-sided, was to try to make sure we bring in some of the other topics. And since there are no questions from the Surgeon General or Health Affairs this time was to try to give you a flavor of what things are being done as a way to perk people's interest and look for areas where you'd like more information. And like I said, you know, use the Subcommittee time that would help out to see what areas you'd like to see.

And what Professor Baker says is very true and in fact along those lines the issue of having a central database for injuries is one of the

big issues for the services.

PRESIDENT PERROTTA: Anything else? Any other business?

DR. ATKINS: Just one thought. And where there are, I've been on the Board long enough to know standard procedure. And where there are specific questions, advanced briefing material, you know, this Board doesn't put a lot of burden on us in terms of reading stuff before meetings. But if that would allow more time for discussion at meetings, I think we could come prepared to discuss things.

PRESIDENT PERROTTA: Okay, meet back at 9:30 and I think we'll wrap up by ten, ten or 10:15.

(Whereupon, the foregoing matter went off the record at 9:01 a.m. and went back on the record at 9:09 a.m.)

(Disease Control Subcommittee joined in progress.)

DR. POLAND: -- and the research dollars that go for epidemiology. Is there a way that we can kind of work that in. I'm Greg Poland.

MR. ZAJDOWICZ: Oh, hi, Thad Zajdowicz, I'm sorry.

DR. LAFORCE: Hi, Mark LaForce.

DR. REINGOLD: I mean, you know, my own personal view in terms of this is that it's, you know, a little fiddling here and there --

(More than one person speaking at a time.)

DR. REINGOLD: -- I guess in terms of the last part it seems to me that, I don't know that particular document, I'm sure it actually says exactly what, you know, fundamentally what, but obviously I think left to our own devices or I would have written the last sentence a little differently. Instead of referring to some, you know, military document, I'd have said that, you know, we think it's extremely important that this group receive adequate funding to get, you know, increased funding to continue its work in these important areas.

I mean, you know, maybe we can then refer to that document. But I think --

DR. LAFORCE: Can we express some concern in terms of, you know the list was going to be shortened in terms of the agents that were going to be looked at. One of the ones that was going to be ripped off was hantavirus. I'm, in order, as a

closer, you know the Board expresses some concern in terms of the projected plans that are likely to eliminate --

DR. POLAND: Actually wasn't it hemmoraghic viruses and --

DR. LAFORCE: Yeah, all research of the stuff on hemmoraghic viruses, yeah, yeah.

CAPTAIN TRUMP: That's exactly what I was saying, I just think we need to be more specific.

DR. LAFORCE: And, yeah, it's not like they don't have a track record or real success, whoa.

CAPTAIN TRUMP: What I had talked to Greg about was that, you know, the way the Military Infectious Disease Research Program is structured, for a lot of reasons, is focused on products, as far as identifying new interventions. Which, you know, I think is a necessary but not sufficient to really say this is the research we need to be doing in military infectious diseases.

And just some closing that, you know, that the epidemiology, the --

DR. REINGOLD: Well, I was saying that I think we need to be more specific in mentioning the loss of research in specific diseases and the need

for increased funding. And then I think we can refer to this document. I mean this document may be well known within military circles, but I'm just saying I think we need to have a couple more --

DR. POLAND: I assume, Dave, that it would be. I mean based on who we're sending the memo to, they would be intimately familiar with what those issues were?

CAPTAIN TRUMP: With the TARA?

DR. POLAND: Yeah.

CAPTAIN TRUMP: Yes.

DR. POLAND: Okay. But I guess my concern when I talked with you, and it made sense to me, is you know you don't want to kind of see-saw this thing. How do we say, in essence, these are important issues and, but oh by the way, there needs to kind of be a balance with the funding for the epidemiology issues. Otherwise you don't know what the next threat is.

DR. LAFORCE: I thought the epi issues were well funded.

CAPTAIN TRUMP: No, he said that's going to --

DR. POLAND: They are always threatened

too.

CAPTAIN TRUMP: No, I mean it's, it's threatened within the area of, you know, our overseas laboratories. They are really not being funded to do epidemiological work, except for, you know, identifying sites for vaccine trials. And so there's not that general funding for, you know, looking at, with the rigor that the research institutions can bring to it. You know, disease impact, emerging threats. You know, what the disease burden might be.

And you know, it's because, you know, they are, have to function in an environment of the Department of Defense which is very much science and technology based on, you know, getting better guns, bullets, MREs, I mean, you know, things, getting things out there rather than necessarily, you know, research for, you know.

DR. LAFORCE: Is there a way for building a case, either in terms of just a sentence or two that has to do with the emerging infections or the interest in emerging infections that are occurring, certainly nationally as well as globally. I mean the CDC is putting, what is it, 250 million dollars or something like that. Is there a Congressional grant

that was given to CDC to do that?

And so therefore to think that you're going to spend that kind of money there and at the same time you already have well functioning laboratories that are located in exactly the places that you want them to be located in, and then say, well, by the way, you can only do this.

CAPTAIN TRUMP: Right, well and some of it --

DR. LAFORCE: That really is fundamentally, it just doesn't make sense.

CAPTAIN TRUMP: -- and some of it does, it has, there needs to be a shift in the way some of our scientists look at things too. Which is, and he mentioned the external peer review is new. Competing for outside dollars, I think, has to become part of the mind set.

DR. LAFORCE: Yeah, I'm not sure a little sentence or a word about the AFEB is delighted in terms of, or strongly supports or supports, whatever it is, this peer review, this changing in funding that occurs, that looks at the issue of peer review. Because I think Charlie has had a lot of flack about, you know, changing this to peer review.

CAPTAIN TRUMP: He didn't mention that.

DR. LAFORCE: Oh, I talked to him after, I talked to him after, until about 6:15 last night. And that's been somewhat painful.

CAPTAIN TRUMP: He's sort of the target.

MS. CANAS: I could mention we do have the Global Emerging Infection System Department now that is looking at, they're funding our flu program and they're over in the overseas labs too.

CAPTAIN TRUMP: That has to be considered part of, you know --

MS. CANAS: Right.

CAPTAIN TRUMP: -- the Department's Infectious Disease research efforts and the funding of epidemiology.

DR. POLAND: Let me catch the two nuances of thought here. One was the recent change to the outside peer review of what though? What's the term that identifies that?

DR. LAFORCE: Funding of investigators under this particular program, under the Military Infectious Disease Research Program in the past was not peer reviewed.

CAPTAIN TRUMP: Well, it was not peer

reviewed outside --

DR. LAFORCE: Outside, right.

CAPTAIN TRUMP: -- of their agency or laboratory.

DR. LAFORCE: And I would think a sentence, yeah, I think a sentence that says the AFEB applauds or supports this change.

CAPTAIN TRUMP: But if you wanted NIH money, you had to --

DR. POLAND: Okay, and then the second one is to say something about, along the lines of, in addition, the Board wishes to emphasize that concomitant funding for infectious disease epidemiologic research is essential to the mission of identifying health threats and protecting.

CAPTAIN TRUMP: That sounds fine. Just getting it in there.

DR. LAFORCE: Or the unique resource that exists in, what do you call them, the Naval or NMRUS, but I'm not sure that the acronym is for the Army?

CAPTAIN TRUMP: Well, it's a mixture, I mean --

DR. LAFORCE: Oh, never mind.

CAPTAIN TRUMP: It's the Overseas Medical

Research Laboratories.

DR. LAFORCE: Okay, Overseas Medical Research Laboratories.

DR. POLAND: It should say then research and the infrastructure to support. Okay, does that kind of capture that? The only other issue really is, which is not a question to the Board, is the issue of the Twinrix vaccine, hepatitis AB vaccine. Now it's not a licensed product in the U.S. at this point, so in some ways I'm not sure that we need to say anything or do anything until such time as it would be licensed. And then you could turn that over to whoever your infectious disease control person is.

DR. REINGOLD: Can you just clarify, because I mean, I, you know, was sort of flipping through the stuff yesterday and trying to remember. The best I can tell from reading the various things, we're already on record as recommending routine hepatitis B vaccination, but that's not happening yet, presumably because of cost and other issues.

CAPTAIN TRUMP: It hasn't survived when --

DR. REINGOLD: Is that right?

CAPTAIN TRUMP: -- other priority issues,

right. And it's cost.

DR. REINGOLD: So, and if I understand correctly from Stan, I mean this new, you know, combination vaccine, presumably there will be a savings in terms of administration costs, but in fact the cost of the vaccine is going to be higher than buying the vaccine individually.

DR. POLAND: Well, that's actually the question I had, is that makes a big difference.

DR. REINGOLD: That's what Stan told me absolutely --

DR. POLAND: It will be higher?

DR. REINGOLD: -- it will definitely be higher. You will pay for the added convenience of having it all in the same bottle.

DR. POLAND: Right. That's too bad.

DR. REINGOLD: So I'm impressed with, you know, the joys of that, but at the moment we can't afford the regular hepatitis B vaccine.

CAPTAIN TRUMP: Right. My suggestion would be, you know, we wait until it's licensed and see what the cost --

LTC. WITHERS: Somehow I got the impression that Smith Kline was going to attempt to

price it just barely above the price of either A or B to, you know, to induce us to buy it.

DR. REINGOLD: The cost of A plus B.

LTC. WITHERS: No, of either A or B.

DR. LAFORCE: No, A or B. Because if that's the case, that's a no brainer. That's a no brainer. That's something that's a very strong recommendation. If they want to get that accepted, boy, that would be one way of doing it is basically charge the same price and you get two.

DR. POLAND: We save the cost of two needles and syringes and the time it takes to do that per person.

MS. CANAS: And compliance.

DR. POLAND: Yeah, and compliance issues.

DR. LAFORCE: That may sell us, but I don't think it's going to --

DR. POLAND: Even if it's a wash in the cost, that would be okay. It's a matter of is it, does it cost $50.00 more to do this.

DR. REINGOLD: Well, we can ask Stan. Obviously, I mean because Stan says that actually Merck is developing an identical vaccine. And I asked him and he said straight out it will be more,

anybody making that vaccine is going to charge more than the cost of the two vaccines alone.

DR. LAFORCE: Doesn't the military, don't you have a special pricing structure. You have special deals.

CAPTAIN TRUMP: They actually, for hepatitis A vaccine what it was, was a, you know, essentially a sole-source contract with the Merck product because we could get the best price deal from them. And I suspect, and I suspect the same thing will happen with, you know, a combination vaccine. I think the issues will be one of, you know, what a recommendation would be for use of the vaccine and I assume potentially in a window of time until we have higher levels of hepatitis B in our incoming recruits, ten years --

DR. POLAND: See that's the balance --

CAPTAIN TRUMP: -- 15 years.

DR. POLAND: -- they will be coming in immune. The other thing is a fair, remember that enough of them entering were 18, what was it, 19 and younger so that they could be recommended, previously they could use half the dose.

CAPTAIN TRUMP: Right.

DR. POLAND: You'd have to take that into account too, in terms of the cost savings. So it seems actually --

CAPTAIN TRUMP: Yeah but the new hepatitis, you know --

DR. POLAND: So it's actually less than the cost of three full doses of hep B based on the way we're doing it now. Or it could be.

CAPTAIN TRUMP: I think immunologically it looks, you know, and the reaction profile looks good.

DR. LAFORCE: There's almost too much A. You know, you can get all the epidemiologic public health benefit out of almost a dose and a half, well certainly two doses. You don't need three doses of A.

CAPTAIN TRUMP: Right. The only reason it's there is because it's the way to package it with B.

DR. LAFORCE: And so the argument, you know, that's why I think the argument is almost strictly a cross block. But this would really be fantastic if the cost really was just a little bit above and not both added together. And they could

still make a fortune doing that. Okay, I had one more item and I wondered whether it was worthwhile putting a sentence in saying that the AFEB was encouraged in terms of the progress that's being made in terms of the adenovirus four and seven vaccine development.

DR. POLAND: And to make an official --

DR. LAFORCE: Yeah, just an official statement. At least they've got, what Charlie seemed to indicate is there was progress that was being made. It sounded like there was more progress, this time than there was last time. Because last time it was very discouraging, I thought.

CAPTAIN TRUMP: The progress is we have money.

DR. LAFORCE: Well, then that's a lot of progress.

LTC. WITHERS: The money has been there for a while.

CAPTAIN TRUMP: Yeah, the corner has been turned, we have a commitment of money which probably is the biggest corner.

DR. POLAND: It might be premature, is what I'm thinking, Mark, about it. Because what's

happened is they've got these small time companies who have said, yeah, who have said, you know, they're kind of interested but there will be some time between building a facility, getting the facility licensed and it's not, just because, was it Grier or somebody else who actually had the license for making adenovirus.

They don't just transfer the license, they'll have to, they'll have to go through review again at the FDA to be sure that it really is made the same way. So it's probably years off.

CAPTAIN TRUMP: Right. I mean the commitment has been made at Health Affairs and further up in the Department to fund a new vaccine which lets Charlie go ahead with things. But they really don't have --

DR. POLAND: All right, but it's good to know that the corner has been turned, as you said.

CAPTAIN TRUMP: And we'll see what happens this year with further developments.

DR. LAFORCE: Then why weren't the drug manufacturers, the large companies, the least bit interested. I mean they looked at Stan, Stan just put his head, you know, this was chump change or

something.

DR. POLAND: Well, it is. There's just not enough call for it. I mean DOD is not big enough by itself.

DR. LAFORCE: Yeah, but I wonder --

CAPTAIN TRUMP: The same thing is happening with the small pox vaccine.

DR. POLAND: I was looking at your data and in some of those cases 60 percent or more of it was adenovirus. I mean no adenovirus is circulating in the community.

MS. CANAS: In the, in the communities, no. In the recruit communities is where it's circulating. It's just background.

DR. LAFORCE: Except that we have, in Rochester, we've got very good viral surveillance stuff. And about every other year, there is an adenoviral -- oh yeah, and it occurs usually in late fall before flu season and everybody thinks it's the flu and it's whatever adenovirus that's actually going through the community. Tremendous morbidity.

DR. POLAND: What I wonder is, I mean the vaccine is a nothing, it's what, two oral doses or something?

DR. LAFORCE: Yeah, it's two oral doses.

DR. POLAND: There's no real reactigenicity.

CAPTAIN TRUMP: It really just hasn't been looked at, I don't think, outside of the military setting.

DR. LAFORCE: But if this company, you know, makes it and certainly wanted to field test it somewhere, you could, I have a hard time figuring out that it wouldn't have some utility in the, you know, because it's so easy to give. The reactigenicity is down and we know that these strains do circulate.

DR. POLAND: The only other thing I might mention is in that, in the vaccines in the military report, we made ten, 11, 12 or so recommendations that you could pass on to your next Infectious Disease Chair to maybe follow up on those and see that, see that, where those are going. A number of them actually have, this has taken long enough that a number of them have already been implemented and are already happening.

CAPTAIN TRUMP: We also encourage you to put in the ones that we, that we're already working on.

DR. POLAND: Right.

DR. LAFORCE: Well, I think that's going to be agenda one on our own agenda next time around. Just basically having a copy of that and say, where are we in terms of these particular recommendations. That's one way of making sure that your work or the Committee's work, when something happens as a result of that. And number two, if there are areas that require a little bit of pushing or changing or massaging, whatever, that we do that.

DR. POLAND: That's the last thing I was going to ask is whether anybody thought there were any kind of infectious disease control-type issues left hanging that we haven't really addressed or haven't dealt with. The one that's kind of surfacing again, based on yesterday's presentation, might be tb. We dealt with that in about '93ish or so.

DR. LAFORCE: Well next time around apparently that's going to be a major focus for the AFEB Meeting, the next one.

DR. POLAND: Oh, is that right.

DR. LAFORCE: As far as tuberculosis. That's what Ben, said.

CAPTAIN TRUMP: Right. Some of the,

probably around the issue of the clinic feron testing. What we should be doing or not doing. You know, we just had another big shipboard outbreak of tuberculosis.

MR. ZAJDOWICZ: The same ship.

DR. POLAND: Really, now isn't that ironic.

DR. LAFORCE: The second one?

MR. ZAJDOWICZ: Patient converter from the first, in essence, stopped her INH and developed active disease.

DR. POLAND: So they don't have, I forgot the term the use, but the supervised --

MR. ZAJDOWICZ: Yeah, they don't use DOT.

DR. POLAND: -- yeah, directly observed therapy?

MR. ZAJDOWICZ: And that clearly is something that --

CAPTAIN TRUMP: The language is there --

MR. ZAJDOWICZ: Correct, we don't do this.

DR. LAFORCE: Because that would be the last thing I would expect in the military.

AUDIENCE MEMBER: How extensive was that

outbreak?

MR. ZAJDOWICZ: I'm sorry?

AUDIENCE MEMBER: How extensive was that outbreak?

MR. ZAJDOWICZ: The conversion rate was a lot less this time. My recollection is was about two or three percent. The first one was 18 percent, I'm not sure. Still, two or three percent is a lot.

CAPTAIN TRUMP: That's a lot, yeah. Plus, well, that one was Marines too, and it became 600 some crew members in the ship's company.

DR. LAFORCE: The lyme disease issue and chlamydia, that's, that's --

CAPTAIN TRUMP: Lyme disease we have a recommendation --

DR. LAFORCE: All of that, there are no problems with that or, okay, fine.

CAPTAIN TRUMP: When we get these policy memos signed out from our level we'll certainly provide copies to the Board at the next meeting.

DR. POLAND: I meant the chlamydia one I think is going to be an ongoing one. As I recall, we kind of, you know, if you want to end up here, we kind of got to about here. In part because it's just

the pure logistics of necessarily screening every male and every female on a repeated basis. So, and also the timing of when that should be done we left kind of at the discretion of the services. I think we just said it had to be done within the first year or something.

DR. LAFORCE: The other thing is, remember we had some recommendations the last time about the epidemiology of lyme disease because there had been a public presentation, one presentation last time and before that there was another presentation, that really were not very sophisticated, not very detailed.

DR. POLAND: In the recommendation that we made about lyme we, they put some recommendations in there about some focus studies that should be done.

DR. LAFORCE: I'm going to ask that that get brought up-to-date, because I really would like that canard to be buried. All of these cases at Hickham or wherever it was and at Walter Reed where all the yuppie, you know, version of lyme disease. Geez, it was really odd.

DR. POLAND: We kind of never came back

to, a few years back we did make a recommendation about some re-vaccination studies for JEV vaccine.

And that, in fact when you said Hawaii, it made me think of it. Because one of the small studies was done there.

LTC. WITHERS: Talking about --

CAPTAIN TRUMP: The appropriate timing --

DR. LAFORCE: The other thing is the status of the dengue vaccine stuff. Because you now have a polyvalent dengue vaccine that's in trial, isn't it? Don't you have a field trial?

DR. POLAND: I think that's what Charlie was getting at, yeah.

LTC. WITHERS: It wasn't clear what, exactly where it was.

DR. POLAND: So you'd like --

DR. LAFORCE: Yeah, that's a big deal.

CAPTAIN TRUMP: You would have to, you'd get a focused presentation on the status.

DR. LAFORCE: Yeah, I'm just asking, I'm not saying, but just to sort of think tank-wise, what areas were of real interest around the re-vaccination in terms of Japanese encephalitis, the follow up in terms of lyme disease.

DR. POLAND: Is Dave Taylor still around? he did the cholera vaccine trials.

DR. LAFORCE: Yes, he's still around. As a matter of fact, they're doing the shigella, that's right. You're doing the shigella field trial now at Mila. And he's involved in that study, is he not? I think so, yeah, I think he is. And that's the other thing for, if there's the R&D stuff, there's been so much progress that's been made in terms of diarrheal vaccines. In particularly the shigella vaccine story. And the cholera vaccine in refugee populations. Well, maybe that's not as much of interest.

But certainly the shigella vaccine story looks like it's becoming now a bit more exciting in terms of having a real shigella vaccine. And you're also doing something on campylobacter, are you not?

DR. REINGOLD: Charlie mentioned --

DR. LAFORCE: You're not doing --

DR. REINGOLD: -- he mentioned the --

DR. LAFORCE: -- did he mention campylobacter?

DR. REINGOLD: -- progress of the campylobacter vaccine, but he --

DR. LAFORCE: Because I don't know anything about a campylobacter vaccine.

DR. POLAND: You know, I'll say the other thing that I think this Subcommittee has been helpful on, and it's not that the military doesn't know what to do with these things, but where I think we have sometimes been very helpful is something like this. Where we find out what's kind of at risk and can provide a supporting memo of an outside Board that says, this is really important.

And I constantly have the feeling that issues surrounding disease control, when they are present, when there is an outbreak, something like that, people pay attention, people who make decisions about funding. But otherwise, it's way in the background, it gets the lowest priority. And particularly the surveillance, the epidemiology is what I worry about.

You know, when there's no obvious direct threat it kind of wanes down there. Adenovirus vaccine is actually a good example of that. DOD had plenty of warning that Wyeth was no longer interested in producing this vaccine.

LTC. WITHERS: That wasn't a surveillance

problem.

DR. POLAND: So just to kind of plant that seed in your, in your ear, Mark, is that that's my own bias. But that's been one of the ways that we've been most helpful is when we kind of get wind of those issues from the PMOs. That's often an opportunity for us to say something supportive that they can then take and shop around to garner support.

DR. LAFORCE: The other thing is from the PMO standpoint. If, do either of you or any of you have any sense of problems that you'd like the Board to sort of look at. Are there any issues that are either percolating out there that the Board might be able to give you a hand. Yes, I know, yes, before the rain.

CAPTAIN TRUMP: I think the anthrax vaccine program is one that, it's going to be there for a long time. There will be future questions. We certainly have a lot of people involved. I think, hopefully, productively and with DOD, Health and Human Services working together on the bioterrorism issue, I think the Board will still have a, you know, a role in that. Maybe not as a, as a group, but

potentially that will come up. So I think, you know, having a strong immunization focus is going to continue to be important.

AUDIENCE MEMBER: Especially when you have small pox and other issues that will be coming up for sure, that's going to happen.

DR. POLAND: I did see in the stripe that there's a small pox trial going on and offering compensation of $770.00.

DR. LAFORCE: For what?

DR. POLAND: I don't know.

DR. LAFORCE: To be immunized against --

DR. POLAND: It's just a little advertisement on a small pox trial. You can't be, we're too old. You can only be up to 33, because we all got the vaccine.

DR. LAFORCE: We got it.

(Laughter.)

DR. LAFORCE: That's going to come back, the issue of small pox vaccine?

DR. POLAND: Oh yeah.

CAPTAIN TRUMP: That is a big issue right now within the Health and Human Services which is to build a stockpile of small pox vaccine.

AUDIENCE MEMBER: Because there is only a small number of doses available at this point.

DR. LAFORCE: And the stoppers are rotting from what I hear.

MR. ZAJDOWICZ: It was a New Yorker article actually a couple of weeks ago about that. And it pointed out that the entire U.S. stock sits in four boxes, four cardboard boxes on a skid --

CAPTAIN TRUMP: No, no, no, no.

MR. ZAJDOWICZ: No, seriously.

CAPTAIN TRUMP: Jim Ladoo has seen the supplies and that is not the case.

MR. ZAJDOWICZ: Fair enough.

DR. LAFORCE: And it's not like we can't make this.

CAPTAIN TRUMP: Well, that's what everybody believes.

DR. LAFORCE: And it's not, right. It's not like we don't know --

AUDIENCE MEMBER: Not like anthrax where we have all these issues --

DR. LAFORCE: I did small pox eradication. That's one thing that we could do.

DR. POLAND: Well, you know now they

won't release them because the lots of --

DR. LAFORCE: Pink vig.

DR. POLAND: -- yeah, the vig has turned pink.

DR. LAFORCE: Yeah, the vig stuff is, that's a different story. That's something that we need to spend some money --

DR. POLAND: But they won't release the vaccine though.

DR. LAFORCE: Right, because we need to spend some money and recreate a source.

CAPTAIN TRUMP: They've gotten, you know, the I&D has been resolved so they can --

DR. LAFORCE: They're working on it.

CAPTAIN TRUMP: Right. So that you can, vig will be available under I&D and they can now go ahead with the vaccine trials for the, you know, for the new vaccine that they're working, have up at Detrick.

DR. LAFORCE: What's the new vaccine?

CAPTAIN TRUMP: It's an MRC five cells using a, a pot picked strain from the Salk TSI which is the Salk Institute strain of small pox.

DR. LAFORCE: Live, killed?

CAPTAIN TRUMP: It will be live, it will be live.

DR. LAFORCE: It's alive.

DR. POLAND: They don't even, there is not even a supply of bifurcated needles.

DR. LAFORCE: I have them. I have them. There are all in a couple of cylinders and they were souvenirs from the small pox eradication process.

DR. POLAND: The next issue is that how few people know how to use that.

LTC. WITHERS: What's a bifurcated needle?

DR. POLAND: Yeah. It's for the skin scratch that they actually administer the vaccine with.

DR. LAFORCE: Yeah, that's how you get the vaccine. It's a needle, that's right. It's shaped like a little fork and it's the most brilliant piece of engineering because it holds a drop in the U that is exactly the right size drop.

DR. POLAND: Yeah, it's .0025 ml.

DR. LAFORCE: And the tines on the fork are beveled such that you can only go so far in the skin and you can inoculate exactly the right amount

of virus.

DR. POLAND: It really is.

DR. LAFORCE: It's a guy from Wyeth and he could have patented it, he could have done whatever. He gave it away. He basically said, look --

DR. POLAND: How many of them do you have?

DR. LAFORCE: I must have 50 or 60. Do you want one?

DR. POLAND: Yeah, I'd like to have one.

DR. LAFORCE: All you have to do is give it to a metal fabricator shop --

DR. POLAND: Just as a souvenir.

DR. LAFORCE: -- and he'll have five million of them in about a week.

DR. POLAND: They actually, they found somebody, in fact I think it was Wyeth who agreed to make them.

DR. LAFORCE: Well, Wyeth, was the original engineer, the engineer was a Wyeth engineer.

DR. POLAND: I'd like to have one just as a souvenir.

DR. LAFORCE: Yeah, yeah, the Wyeth guy

was an engineer who worked at Wyeth who did this.

MR. ZAJDOWICZ: So these vaccines, these vaccine issues with terrorism, you know, how we can use a vaccine, you know, how we would, when we would use small pox vaccine, are going to get pulled into ACIP discussions too, I think. But the civilian use of anthrax vaccine is going to --

DR. LAFORCE: This is amazing. That poses another issue. Here, you know, at 60 years of age I turn out to be, I've worked up the last case of inhalation anthrax in the United States. Also, worked up, you know, the small pox eradication program and the malaria eradication program. So at age 60 I found out that just by living, I've become an authority --

DR. POLAND: You're the possessor of the history.

(Laughter.)

DR. LAFORCE: It has nothing to do with brains, it all has to do with how long you live.

DR. POLAND: Remember in prehistoric times, a guy, a guy in your position was the one responsible for keeping the spark --

DR. LAFORCE: Oh, yeah, yeah, yeah.

DR. POLAND: -- the ember.

(Laughter.)

DR. POLAND: So that the next group could have a fire.

DR. LAFORCE: I think it's the funniest thing in the world.

CAPTAIN TRUMP: Well, I mean that's the question of folks at USAMRIID are asked. Is have you seen a case of inhalation anthrax? Well, no.

DR. LAFORCE: It's an awful disease.

CAPTAIN TRUMP: I now have a name of someone who has seen a case of inhalation anthrax.

DR. LAFORCE: It's an awful disease. They all die.

DR. POLAND: Actually you know who published some, the, some of the early U.S. series on anthrax was Stan Plotkin.

DR. LAFORCE: Yeah, Plotkin and Brachman published, Plotkin and Brachman published the classic clinical paper.

DR. LAFORCE: I suppose something else that could circulate back to this Committee in time is recommendations, as it further materializes, is what the DOD program would be for pandemic influenza.

DR. POLAND: Yes.

DR. LAFORCE: Because the surveillance, that was very impressive by the way. The surveillance activities that you -- I thought that was pretty cool.

DR. POLAND: You know what I was surprised at is all the time on VRBPAC and everything else, as you said, last year was the first time you were there. I don't think it's widely known or appreciated that there's that resource and that there's that --

CAPTAIN TRUMP: Well, I think CDC knows and appreciates it.

DR. LAFORCE: And WHO must because you're a regional center for WHO, aren't you?

PRESIDENT PERROTTA: Maybe we'll send you some from TDH.

(A lot of people talking at once.)

MS. CANAS: But the nice thing about it is it's a system in place. And if there's something else going on we're going to pick that up too.

DR. POLAND: And the joke is, you know, we work with all these viruses and bacteria and we do all these good things for people, but they won't

shake our hand.

(Laughter.)

DR. POLAND: Dave were you going to say anything.

CAPTAIN TRUMP: No, I was going to say, you know, the Global One Emerging Infection Program does have, you know, is working with the DOD Pandemic Influenza Plan as part of, you know, sort of the national plan. That national plan though is right now, I guess the science and program side has been done, but it's now up at the policy level as far as decisions about implementation and paying for it. It always seems to be that thing that slows things down in D.C. is paying for it.

DR. POLAND: Maybe Disease Control should go visit her --

CAPTAIN TRUMP: Budget, yeah.

DR. POLAND: -- place and see what we can do to be supportive.

MS. CANAS: Okay.

CAPTAIN TRUMP: And policy issues like --

DR. POLAND: Seriously.

CAPTAIN TRUMP: -- indemnification for the vaccine manufacturers.

PRESIDENT PERROTTA: There's a real interest on Ben's part to go to San Antonio for your next meeting.

AUDIENCE MEMBER: You could do a tour. You could come to the school house at Brooks.

PRESIDENT PERROTTA: There will be lots of stuff that comes up.

DR. LAFORCE: What's the school house at Brooks?

AUDIENCE MEMBER: It's a new facility. It's just this --

DR. LAFORCE: Oh, it is, oh, that's what they call it, the school house?

AUDIENCE MEMBER: -- school based medicine and it has a nice --

DR. LAFORCE: I thought it was some --

AUDIENCE MEMBER: It's beautiful.

DR. LAFORCE: -- you know, Davy Crockett was educated in this, you know, school or something.

(Laughter.)

AUDIENCE MEMBER: No.

PRESIDENT PERROTTA: Is that along the highway there or where is it?

AUDIENCE MEMBER: It's just off of 35 as

you're going towards Corpus Christi. And it's a little base so, and it's got good facilities there that you could use.

DR. POLAND: I don't think we have anything else.

DR. LAFORCE: No. Sounds great, thank you.

(Whereupon, the foregoing matter went off the record at 9:43 a.m. and went back on the record at 10:08 a.m.)

PRESIDENT PERROTTA: Let's reconvene the Executive Session and then start with the reports from the different Committees. Let's see, Disease Control.

DR. POLAND: We discussed, we discussed two issues. One was about the combined hepatitis AB vaccine and we decided to table it for the time being since there isn't a currently licensed U.S. vaccine. And did have some discussion about that the major issue would be the cost-effectiveness of going to a vaccine like that. So we will leave that for the people who come after us.

(Laughter.)

DR. POLAND: We do have a recommendation for the Board that I'd like to just read and it was based on a presentation by Charlie Hoke yesterday and then discussions with some of the Preventive Medicine Officers and others. And that concerns the Military Infectious Disease Research Program. So if you'll allow me to just read this.

"The Military Infectious Disease Research Program has a long and distinguished history of research and development on infectious diseases and is tightly focused on the goal of finding solutions to diseases of military importance.

Because recent licensures of vaccines for Japanese encephalitis and hepatitis A and the anti-malarial drugs, mefloquine and halofantrine, should be considered successful examples of accomplishments by this program. Notable products in the development phase include candidate malaria vaccines, malaria drug development, development of candidate vaccines for diarrheal diseases, dengue and hantavirus.

The Board wishes to express support for this program. In particular, the Board applauds and supports the recent change to outside peer review of the MIDRP Program. Further, the Board recommends

that the funding and personnel issues identified in the 1999 Technology Area Review and Assessment held by the Director for Biosystems, Office of the Director of Defense, Research and Engineering, be addressed, especially in sustaining funding for hemorraghic viruses and hantaviruses.

Finally, the Board wishes to emphasize that concomitant funding for infectious disease epidemiologic research and the supporting infrastructure is necessary to the mission of identifying health threats and protecting military personnel." I guess what I would like is at least a tentative vote or approve, let me say it a different way.

A vote on this draft. We'll clean the language up a little bit and work some of the grammar here, but approval by the Board for this.

PRESIDENT PERROTTA: So you make that into the form of a motion then?

DR. POLAND: Yes.

PRESIDENT PERROTTA: I have a motion on the table, do I here a second?

DR. LAFORCE: Second.

PRESIDENT PERROTTA: Motion and the

second, is there discussion necessary?

DR. SOKAS: We'll regret the lost opportunity --

PRESIDENT PERROTTA: Or maybe you can say ditto and then just put injury --

DR. SOKAS: There you go, there you go.

PRESIDENT PERROTTA: -- in there for your --

DR. SOKAS: Okay, ditto injury, okay.

PRESIDENT PERROTTA: Any further discussion?

COLONEL DINIEGA: I have a question. This is going to go to Health Affairs, right?

DR. LAFORCE: Right.

COLONEL DINIEGA: And it will be a memo based on hearing the briefing on --

DR. POLAND: Maybe I should say that in fact that the Board heard that.

PRESIDENT PERROTTA: Further discussion?

(No response.)

PRESIDENT PERROTTA: Hearing none, all those in favor of this motion signify by saying aye.

(Chorus of ayes.)

PRESIDENT PERROTTA: All those opposed,

like sign?

(No response.)

PRESIDENT PERROTTA: Motion carries. So we'll write it up and get it sent to the office. Anything else for your Committee?

DR. POLAND: No, done.

PRESIDENT PERROTTA: Dr. Anderson.

DR. ANDERSON: Okay.

PRESIDENT PERROTTA: Environmental Occupational Injury.

DR. ANDERSON: We had a good discussion today and we just wanted to applaud the agenda for this meeting that covered lots of issues, unlike the last session where we were focused predominantly on infectious disease issues. And we would like to advocate for continued focus, at least part of each session on injury issues as well as the occupation and environmental.

We also really appreciated receiving the copy of the large injury report. Although two large reports to carry home at the same time, we'd like to balance out when we get the large carrying cases. And that segues into the next issue which we'd like to see perhaps discussed at the next meeting and that

deals with back injuries. Those of us who have to hoist our suitcases into the overhead racks on the way home.

So there was two things. One, to address perhaps back injuries as a discussion topic. Another was, there's a whole set of recommendations in this large injury report that we haven't had a chance to take a look at. But we thought it would be well worth following up on what are the various branches' strategies to respond to those recommendations. And we would like to follow up with greater discussion on those recommendations and maybe hit some priorities.

And since funding is an issue that maybe one thing we may want to look at, as well as the need for specific injury centers. The other area that we discussed, oh, we also thought at the next meeting, if we are going to have some injury presentations, we ought to be sure and invite the injury, the individuals at NIOSH and perhaps at the CDC Injury Center as well to participate in the discussion.

That would be especially true if we'll have sufficient time for a more in depth discussion at a breakout session. And that may specifically address the injury report and how we might follow up

with implementing those or assisting in implementing those recommendations. We also then were very interested in the case report on the building issue and felt that it would be very helpful and we might be able to help with various aspects of how to investigate these and how to interpret and provide information on older buildings.

And we thought it would be worthwhile to ask other similar investigations underway what is the environmental priorities for the investigation individuals. I think in the past we've heard about the work of looking into the way sites and more typical and the superfund type issues. But this was the first time we've heard about the rehabing or shifting around of use of buildings and thought it would be worthwhile to see what are the current protocols.

Are there other projects. And then we could get some advice on how best to evaluate those in the utilization of environmental personal hair sampling as well as bio-monitoring to help interpret some of these. Lastly, we talked some about the difficulties of what are the appropriate exposure environmental measurement standards to use under

various scenarios, be it deployment or garrison.

We understood there is a developed, or under development some models that are being worked on and comparative standards as to what's the appropriate or should there be separate standards that the military uses somewhere in between the OSHA standards for work place and the EPA environmental targets. And we thought at some point we'd be interested in having a presentation and discussion on the methodologies that are being developed, as well as the risk communication issues that will certainly play or continue to play in interpretation of environmental monitoring data.

So we had a good half hour and a half discussion and I look forward to the next meeting.

PRESIDENT PERROTTA: No recommendations?

DR. ANDERSON: No recommendations.

PRESIDENT PERROTTA: Okay. Dr. Haywood.

DR. HAYWOOD: Can you hear me? Well, my Committee has the unique position of not having Dr. Bowman as its Chair, so we haven't had the consistent leadership that would be desirable to have an effective committee. We're about to recommend the solution to that. In the meantime, since we meet

each time for the first time and this time we discussed the issues that we discussed the last time. Which is what should our Committee be doing.

Well, we redefined that there are several important issues that our Committee should be addressing. Mainly, what is its role in terms of advice, giving advice in regard to specific issues that are raised to the Committee in regard to guidelines and implementation of specific programs, such as the HEAR Project. Review policy and programs and position statements that might come before the Committee.

And address initiative policy that we might want to promote to the Armed Services through the advice of the Board. And finally, advocacy. We can be advocates of those policies that the Service Chiefs wish to bring to us for review and advice and therefore adoption by the Board and recommendation. Involved in these areas are standards and regard to standard development methods, our proven methods, reviewing methods, implementation tool kits, etcetera. Setting goals, reviewing bench marks, trying to identify who the decision makers are when individual issues of policy are raised by

individual services. And trying to address some of the cultural issues that seem to be persistent, evasive and likely to be important in addressing implementation at the operational level. So that's basically I think the substance of our discussion.

Recommendation that Dr. Atkins replace Dr. Larosa as the Chair of the Committee. Dr. Atkins do you want to have any comments in that regard?

DR. ATKINS: Dr. Larosa is leaving, is rotating off the Board.

DR. POLAND: It's not a coup.

(Laughter.)

DR. ATKINS: I said this is conditional that I not be expected to produce a report this size.

(Laughter.)

PRESIDENT PERROTTA: Thank you. It's my understanding and I think this probably makes an awful lot of sense that it's up to the decision of the President of AFEB to name the Chairs of the three Committees, the three standing Committees. And any other Committee -- right. And so I think the new, the incoming President should be given the authority to wipe the slate clean or continue people without prejudice or whatever. And so that advice would be

something that Mark would need to take from your Committee. Okay, any other questions or comments. Do we have any other business?

DR. LAFORCE: I have one question. Was there any discussion about the presentation on the survey of health related behaviors, the presentation by Dr. Bray? Or maybe I don't have that, yes, yes, I do.

DR. ATKINS: We specifically asked Dr. Bray to join our discussion and I think there are a couple of issues. One was the issue of using that survey to identify sort of population health goals and the possible link with healthy people in 2010 as a way of identifying population health goals that the military might be measured against.

And the other issue was the multiplicity of surveys that are going on in the military and Dr. Bradshaw talked about some efforts at consolidating those surveys and the role of information that can be gotten through the health risk appraisal versus from surveys. So I think that's a process of evolution in terms of the information we use to measure population health in the military.

DR. LAFORCE: But the other issue was the

decrease from about 85 percent or 89 percent acceptability down to levels now that, unless there is some sub-survey of the non-responders, it's really sort of hard to figure out how useful this information is. I mean, and that was the, one of the areas that I was curious about.

COLONEL BRADSHAW: Yes, this is Dana Bradshaw. One of the issues was the survey. When there's been an expansion in the number of surveys and people are getting surveys all the time. So obviously that impacts overall response. So when your office did the survey, people start getting tired of it. I think the second thing would be that we could consider whether or not we should make a recommendation that maybe there should be something added to the world wide survey in terms of doing a survey in response either, you know, oversampling or going back and doing a telephone survey of non-respondents.

Or just using survey techniques to go back and say, are these people different than the people who did respond. So I don't know if the Board wants to make that sort of recommendation or if you think that would be helpful, Dr. Bray?

DR. BRAY: Well, it's problematic in that it's an anonymous survey.

COLONEL BRADSHAW: Right. Well, I think with the BRFS, BRFS is a behavioral risk factor survey that we do, that is done by telephone and it's still considered anonymous.

DR. BRAY: I take it back. We know who they are, we just don't know which questionnaire they completed. So you could go back and do a subset of people.

DR. ANDERSON: Yeah, the same concept. You invite people to participate so you know who you invited. You can go back to them and either ask why they didn't participate --

DR. BRAY: No, we --

DR. ANDERSON: -- get some basic demographics, their age or other characteristics.

DR. BRAY: We've got demographics from sampling and we can at least look that far.

COLONEL BRADSHAW: There are probably ways to work on that, I think within the structure and the methodology, but I don't know if we, obviously it's a concern.

DR. LAFORCE: Yeah, because the reason

why I'm bringing this up and we talked about this at dinner last night. That there are really some far-ranging conclusions that you're making from these data and, you know, they're only as good as the survey results themselves.

COLONEL BRADSHAW: There are some other ways of comparing at least certain data. The anonymous type questions, you know things that are a little more private in nature like the sexual behavior or whatever, those are probably more difficult. But in the Air Force we do have the BRFS, which is a telephone-based survey that we can compare similar questions on the HEAR. We can compare, we also have smoking cessation data and smoking status.

So there are certain subsegments that we can compare and validate what we get from the world wide survey on, but you know, I guess where we don't have duplication or another way of validating the information from another source, then you need to look at different ways of validating that.

DR. LAFORCE: No because you're, the, one of the discussion points yesterday was declaring a win in terms of substance abuse. That was clear cut in terms of that. That's in a very, very important

statement on the part of everyone, preparedness, etcetera. And I think it's frankly pretty risky to make that sort of statement because that's precisely the individual who would not fill out a form that --

DR. BRAY: Well, that's actually the easy one because of urinalysis.

DR. LAFORCE: Okay, fine, fine. So you feel pretty, okay, okay.

COLONEL DINIEGA: I think there's a --

DR. BRAY: The point is still well taken, overall, there's an issue there.

COLONEL DINIEGA: There may be a bigger question. They've been doing the surveys since the early, '83. They've been doing the surveys since the early '80's and I think the purpose that the survey was chartered may have changed. Because in those days we didn't have a lot of automation support. So I think when they say that there are other areas to confirm and getting an inkling if the trend is correct or not, it's because we're getting more automation and have other ways to find the same data.

It also has transitioned from, if I'm not mistaken, from a personnel directed survey to a health affairs chartered survey. So, it's always

been health affairs? And so, you know, health affairs wants the survey, so the question is what do they use it for? Is it to see how we're meeting healthy people 2000 goals now? That's the other issue.

DR. HAYWOOD: These are precisely the goals that we thought should be addressed on the issue. What the intelligence survey and what's the marginal benefit from year to year after you looked at a certain type of data, should it be continued. And the other issue that's overall related to this is the across the board applicability of standards across the services, and that's an issue that really needs attention paid to it.

PRESIDENT PERROTTA: Anything else?

(No response.)

PRESIDENT PERROTTA: PMOs, ladies, gentlemen, lady, gentlemen?

(No response.)

PRESIDENT PERROTTA: Okay, perhaps I'll take this opportunity to again thank everyone for their input and work on this, absolutely everyone in the room and those who have gone before us. Thanks personally to each one of you for making this a very

enjoyable experience for myself and I wish you and your new President very well. The last bit of business is that the Petty Officer is arranging for a van or some other transportation to the Metro Station since most of us can make airplanes using the Metro. So if you just hang tight here until he returns, then that should be in another ten minutes. And if anybody else has anything else, seeing none, hit it. Thank you.

(Whereupon, the public meeting was concluded at 10:30 a.m.)